Date: ____ No. of pages: ________________

To: Keturah Health, LLC   Fax: (469) 857-8492   Email: keturahnp@keturah-hms.com

From: ____ Title: ________________________

Phone: _______________________________________ Fax: _________________________

PATIENT INFORMATION

Name of patient: ______________________________DOB: ________________________

Interpreter needed: Yes   No   Language: __________________________

Home phone: ____

Address: _________________________ City: ________________Zip: ________________

Insurance: Include patient's insurance card (both sides) and authorization if required.
CONSULTATION REQUEST INFORMATION Diagnosis/ICD10 Include medication requisition, face sheet, most Resent Progress note.

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By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION
Referring MD/PCP:______________________________ Specialty:___________________

Phone:____ Fax:________________________

Signature: ____
NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated